

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07765

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 24 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34		d. STREET ADDRESS 9033 Simms Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Harold Adams				4. DATE OF DEATH Month Day Year July 25 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1879	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist & Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Adams				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -		16. SOCIAL SECURITY NO. 216-20-8827		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. senile brain disease.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1-1961 to 7-25-1961 that (I) (we) last saw the deceased alive on 7-25-1961 , and that death occurred at 10:35 p.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Julian Radzykewycz</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-25-61	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-28-1961		23c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran		23d. LOCATION (City, town or county) (State) Blenheim, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home 7401 Belair Rd.</i> ADDRESS				25a. REC'D BY REGISTRAR DATE JUL 27 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7775

CERTIFICATE OF DEATH

07766

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore #12</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>524 Rossiter Ave.</u> d. STREET ADDRESS <u>524 Rossiter Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie Josephine ADAMS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/73</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u>	11. IF UNDER 24 HRS. Hours <u>11</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Adams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Springfield Hospital Records</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia.</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>4902</u> DUE TO (c) <u>4902</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GBS assoc. with senile brain disease, with psychotic reaction.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/22/61</u> to <u>7/21</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>7/21</u> , 19 <u>61</u> , and that death occurred at <u>11:10 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis J. Rzewy</u>		22b. DATE SIGNED <u>7/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julian Radzykowycz, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-24-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DEVID RIDGE</u>	23d. LOCATION (City, town or county) (State) <u>PIKESVILLE</u> <u>MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 25 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HOWARD (3044) 402 York Road
1-24-61 DEPT. OF
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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07767	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. City					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb 5yrs. 1mo.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				3001-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 2436 St. Paul St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Earl Last Adams			4. DATE OF DEATH Month July Day 6, Year 1961								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1906		9. AGE (in years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker for freight company.				10b. KIND OF BUSINESS OR INDUSTRY Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James B. Adams						14. MOTHER'S MAIDEN NAME Agnes Ellis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Bronchial occlusion (c) Aspiration of food										INTERVAL BETWEEN ONSET AND DEATH Minutes 11 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. assoc. with CNS Syphilis, meningoencephalitis with psychotic reaction.											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Apparently aspirated food							
20c. TIME OF INJURY Month, Day, Year Hour e.m. - p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) S.S. Hospital		20f. (City or town) Sykesville		(County) Carroll	
(State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 7/6/61		
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/61		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		22d. LOCATION (City, town, or country) Ritchie Hwy		(State) Md.			
23. FUNERAL DIRECTOR John J. Conners						24a. REC'D BY REGISTRAR Jul 10 '61		24b. REGISTRAR'S SIGNATURE Arthur L. King			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07768

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 mo. 16 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Littlestown (Mailing Address) d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nettie Christie Benton		4. DATE OF DEATH Month 7 Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81 Days 17 Hours 17 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James R. Christie		14. MOTHER'S MAIDEN NAME Eliza Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction INTERVAL BETWEEN ONSET AND DEATH three weeks years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1-1961 to 7-17-1961 , that (I) (we) last saw the deceased alive on 7-17-1961 , and that death occurred at 9:00 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Radzykewycz M.D.		22b. DATE SIGNED 7-17-61	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town or county) (State) Littlestown, Adams Co., Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		25a. REC'D BY REGISTRAR DATE JUL 19 '61	
ADDRESS Littlestown, Pa.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7778

Item 9 Film 0290

7/18/61 mh

07769

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c. LENGTH OF STAY IN 1b 4y 1mo. 10d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 10 E. Pratt St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Max Middle Berger Last Berger		4. DATE OF DEATH Month 7 Day 10 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-18-1887
9. AGE (In years last birthday) 73 1/4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Israel Berger	
14. MOTHER'S MAIDEN NAME Sophia Friedman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old and new myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to arteriosclerosis DUE TO Softening of brain due to arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH months years months years	
21. I certify that (I) (this hospital) attended the deceased from 9 month 19 60 July 10 1961 , that (I) (we) lost saw the deceased alive on July 10 19 61 and that death occurred at 1 P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Yasuo Takahashi, M.D.		22b. DATE SIGNED 7-10-61	
22c. PHYSICIAN'S NAME (Type) Yasuo Takahashi		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-14-61	23c. NAME OF CEMETERY OR CREMATORY Rosedale	23d. LOCATION (City, town, or county) (State) Baltimore Md
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		25a. REC'D BY REGISTRAR DATE JUL 14 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Hume			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 36 yrs 8 dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2528 N. Calvert St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle B. Last Booth			4. DATE OF DEATH Month July Day 25 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown John Gilbert Booth				
14. MOTHER'S MAIDEN NAME Unknown Ida L. Matthews		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				
16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease. DUE TO (c) Schizophrenic reaction, paranoid type.						INTERVAL BETWEEN ONSET AND DEATH Instant Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) 17		20g. (County) 1925		20h. (State) July 25, 1961		
21. I certify that (I) (this hospital) attended the deceased from July 17, 1925 to July 25, 1961, that (I) (we) last saw the deceased alive on July 25, 1961, and that death occurred at 5:10 PM from the causes and on the date stated above.						
22a. SIGNATURE Julian Radcykowycz M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/26/61		
22c. PHYSICIAN'S NAME (Type) Julian Radcykowycz, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-29-61		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove		
23d. LOCATION (City, town or county) Baltimore Co., Md.		23e. (State) Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR AUG 1 '61		
25b. REGISTRAR'S SIGNATURE William L. Hines		DATE				

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Handwritten signature and text at the bottom of the page, including the name "John A. ...".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7780

CERTIFICATE OF DEATH

07771

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 69n.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wm. M. Minton</u>		d. STREET ADDRESS <u>1 Wm. Minton</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH BROWN</u>		4. DATE OF DEATH Month Day Year <u>JULY 5 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11c. BIRTHPLACE (State or foreign country) <u>Bishopville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Bunting</u>		14. MOTHER'S MAIDEN NAME <u>Vernie Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Brady C. Bryson</u> Address <u>Westminster Rd. 7nd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> 422.1 DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> 19 <u>61</u> to <u>July 5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> 19 <u>61</u> and that death occurred at <u>11</u> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James T. Marsh</u> M.D.		22b. DATE SIGNED <u>7/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		22d. ADDRESS <u>Westminster Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Centerville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>July 10 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Knapp</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7781

07772

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 11mos. 5days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3109 Louise Avenue			
3. NAME OF DECEASED (Type or print) First George Middle Edward Last Burlage				4. DATE OF DEATH Month July Day 7 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 17, 1874		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Katherine -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1, 1957 to July 7, 1961 , that (I) (we) last saw the deceased alive on July 7, 1961 , and that death occurred at 8:25AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/7/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) BALTO Md	
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Kuck				ADDRESS 5305 Hanford Rd		25a. REC'D BY REGISTRAR DATE JUL 10 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. K...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7782

07773

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> d. STREET ADDRESS <u>Sykesville -</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mittie</u> Middle <u>Susan</u> Last <u>Carlyle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Berkley Upchurch</u>	
14. MOTHER'S MAIDEN NAME <u>Ursula</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene, left leg</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>peripheral insufficiency</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome, cerebral arteriosclerosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-28-</u> <u>1961</u> , to <u>7-12-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7-12-</u> <u>1961</u> , and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo</u> M.D.		22b. DATE SIGNED <u>7-12-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-14-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Upchurch</u>	23d. LOCATION (City, town or county) (State) <u>Franklin County, N.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 17 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7783

CERTIFICATE OF DEATH

07774

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster PO #2</u>				d. STREET ADDRESS <u>Backmans Valley</u>			
3. NAME OF DECEASED (Type or print) <u>DAVID WHITTAKER CHAMBERS</u>				4. DATE OF DEATH <u>July 9 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired editor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>magazine</u>			
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sam Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Lela Whittaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Mr. Esther S. Chambers</u> Address <u>same address</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>12 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 19 1961</u> to <u>July 9 1961</u> , that (I) (we) last saw the deceased alive on <u>May 10 1961</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Reese Wilkens</u> M.D.				22b. DATE SIGNED <u>7/9/61 md.</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens</u>				22d. ADDRESS <u>15 KEMPER, Westminster</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>7/11/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd. DC</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>CLARA L. THOMAS</u> DATE <u>JUL 12 '61</u>			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7784

07775

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 6yrs.1mo.16days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS Broadway and Fairmount Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace DeWalden Chancellor		4. DATE OF DEATH Month Day Year July 17 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1865
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Smith	
14. MOTHER'S MAIDEN NAME Addis W. Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Renal insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sclerosis, with psychotic reaction. C.B.S. associated with circulatory disturbance, with cerebral arterio-			
INTERVAL BETWEEN ONSET AND DEATH months weeks Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-31-1955 , to 7-17-1961 , that (I) (we) last saw the deceased alive on 7-17-1961 , and that death occurred at 1:40 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Radzykewycz M.D.		22b. DATE SIGNED 7-17-61	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-18-61	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Wm. Cook, Inc., 1517 St. Louis Street

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7785 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G292 8/4/61 jmk

07776

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Michigan b. COUNTY Detroit			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detroit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clearview Motel				d. STREET ADDRESS 6200 Ashton			
3. NAME OF DECEASED (Type or print) BERNARD AUGUSTA CLINGAN				4. DATE OF DEATH Month July Day 30 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1906	
9. AGE (In years last birthday) 54 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Janetown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham L. Clingan				14. MOTHER'S MAIDEN NAME Emma Storm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?				16. SOCIAL SECURITY NO. ?			
17. INFORMANT DAVID N. CLINGAN, WESTMINSTER, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 422.1 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. W. Rieckert EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Associate Pathologist x DEPUTY MEDICAL EXAMINER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/4/61			
22c. NAME OF CEMETERY OR CREMATORY GRAND LAWN CEM.				22d. LOCATION (City, town, or country) (State) DETROIT Michigan			
23. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.				24a. REC'D BY REGISTRAR AUG 2 '61			
24b. REGISTRAR'S SIGNATURE Carling S. Harris							

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

CERTIFICATE OF DEATH

Reg. Dist. No.

07777

7786

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marcheson</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prestonsville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i> | | d. STREET ADDRESS <i>03 X-</i> | |
| 3. NAME OF DECEASED
(Type or print) First <i>Mary</i> Middle <i>ANNA</i> Last <i>Cole</i> | | 4. DATE OF DEATH Month <i>July</i> Day <i>17</i> Year <i>1961</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 5, 1874</i> |
| 9. AGE (In years last birthday) <i>87</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Rev. Charles T. HARVEY</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Brown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>none</i> | 17. INFORMANT Address <i>Wilbur W. Cole HAMPSTEAD MD</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i>
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
?
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month _____ Day _____ Year <i>19</i>
Hour _____ o. m. _____ p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <i>5-15-</i> , 19 <i>58</i> , to <i>6-17</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>6-16-</i> , 19 <i>61</i> , and that death occurred at <i>10:20 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Joseph E. Bush</i> M.D. | | ADDRESS (Street, city or town, state) <i>Hampstead Md</i> DATE SIGNED <i>7/17/61</i> | |
| PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i> | | <i>HAMPSTEAD MD</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>7-20-61</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Lipton-Elmer</i> ADDRESS <i>Hampstead Md</i> | | 24a. REC'D BY REGISTRAR <i>DATE JUL 24 '61</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

| | | | |
|---------------------------|--|---------------|--|
| PLACE IN DEATH | | MAYLAND | |
| A. NAME OF DECEASED | | J. M. SMITH | |
| B. SEX | | Male | |
| C. AGE | | 45 | |
| D. OCCUPATION | | Carpenter | |
| E. PLACE OF BIRTH | | Maryland | |
| F. DATE OF DEATH | | Jan 15 1911 | |
| G. TIME OF DEATH | | 10:30 AM | |
| H. CAUSE OF DEATH | | Heart Disease | |
| I. PLACE OF DEATH | | Home | |
| J. SIGNATURE OF PHYSICIAN | | J. M. SMITH | |
| K. SIGNATURE OF WITNESSES | | J. M. SMITH | |
| L. SIGNATURE OF DECEASED | | J. M. SMITH | |
| M. SIGNATURE OF CLERK | | J. M. SMITH | |
| N. SIGNATURE OF REGISTRAR | | J. M. SMITH | |
| O. SIGNATURE OF NOTARY | | J. M. SMITH | |
| P. SIGNATURE OF JUDGE | | J. M. SMITH | |
| Q. SIGNATURE OF SHERIFF | | J. M. SMITH | |
| R. SIGNATURE OF CORONER | | J. M. SMITH | |
| S. SIGNATURE OF JURY | | J. M. SMITH | |
| T. SIGNATURE OF COURT | | J. M. SMITH | |
| U. SIGNATURE OF STATE | | J. M. SMITH | |
| V. SIGNATURE OF NATION | | J. M. SMITH | |
| W. SIGNATURE OF WORLD | | J. M. SMITH | |
| X. SIGNATURE OF UNIVERSE | | J. M. SMITH | |
| Y. SIGNATURE OF GOD | | J. M. SMITH | |
| Z. SIGNATURE OF DEVIL | | J. M. SMITH | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7787

Item 9 Film 6-290

7/10/61 iwk

CERTIFICATE OF DEATH

07778

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
1yr. 3mos. 16days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
7913 Elmhurst Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Sarah Middle Elizabeth Last Cole | | 4. DATE OF DEATH
Month July Day 5 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 27, 1880 |
| 9. AGE (In years last birthday)
81/80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Spencer Warren | | 14. MOTHER'S MAIDEN NAME
Maggie White | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia with lung abscess
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease
DUE TO
(c) Chronic Brain Syndrome associated with senile brain disease reaction, with psychotic | | | |
| INTERVAL BETWEEN ONSET AND DEATH
days
years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease reaction, with psychotic | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 19, 1960 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 9:20 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22b. DATE
7/5/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23b. DATE THEREOF
7-8-61 | | 23c. NAME OF CEMETERY OR CREMATORY
York Methodist | |
| 23d. LOCATION (City, town, or county) (State)
York, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lemard Luck ADDRESS 5305 Hayford | | 25a. REC'D BY REGISTRAR
DATE JUL 6 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kneas | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE

1917

(M)

Department of Agriculture

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7788

07779

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | | | c. LENGTH OF STAY IN 1b
75 Years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Westminster, Md. R.D.2 (Union Mills) | | | |
| d. STREET ADDRESS
Westminster, Md. R.D.2 (Union Mills) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Anna Last Crowl | | | | 4. DATE OF DEATH
Month July Day 19 Year 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 5, 1883 | |
| 9. AGE (In years lost birthday) yrs. 78 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife-Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Her own home | | 11. BIRTHPLACE (State or foreign country)
Lancaster Co., Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Austin Myers | | | | 14. MOTHER'S NAME
Elizabeth Metzler (Elizabeth Metzler) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
220-03-2908A | | 17. INFORMANT
Garfield D. Crowl, Westminster, Md. R. D. 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO 443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease
DUE TO (c) 10 years | | | | INTERVAL BETWEEN ONSET AND DEATH
9 hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 2, 1961 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 18, 1961 , and that death occurred 2:15 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
R. R. Potter | | | | M.D. X MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
July 19, 1961 | |
| 22c. PHYSICIAN'S NAME (Type)
L. L. POTTER M.D. | | | | 22d. ADDRESS
LITTLESTOWN, PA. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/22/61 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys Cemetery | | 23d. LOCATION (City, town, or county) (State)
Silver Run, Carroll Co., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Richard A. Little, Littlestown, PA | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUL 24 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hirsch | | | | | | | |

M

I

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7789

CERTIFICATE OF DEATH

07780

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u> | c. LENGTH OF STAY IN 1b <u>12 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mt. Airy</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Golden Age Guest Home</u> | | d. STREET ADDRESS <u>R. D #2,</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Goldia</u> Middle <u>V.</u> Last <u>DAVIS</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-15-88</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Levi FRIZZELL</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Virginia ?</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>Mr. Allee C. Davis, R.D. 2, Mt. Airy, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u>
1539 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Intestines</u> DUE TO
(c) <u>3 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1961</u> to <u>July 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1961</u> , and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Arthur H. Martin</u> | | 22b. DATE SIGNED <u>July 23, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MORRELL N. MARTIN, MD.</u> | | 22d. ADDRESS <u>Sykesville Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>July 26-1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church & God Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>CARROLL Co., Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 27 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | | | |

10750

CERTIFICATE OF DEATH

1188

M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7790

CERTIFICATE OF DEATH

07781

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Taneytown</u> | | | | c. LENGTH OF STAY IN 1b
<u>1 YEAR</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>22 W. Baltimore Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Elsie</u> Middle <u>Belle</u> Last <u>Dutrow</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>14</u> Year <u>19 61</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 11, 1884</u> | |
| 9. AGE (In years last birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Elias Singer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>220-26-5668</u> | | 17. INFORMANT
<u>Mrs. Myrle Devilbiss, Taneytown, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u>
<u>4201</u> DUE TO (b) <u>Coronary Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>Few Min.</u>
<u>15 yrs.</u>
<u>15 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> <u>1946</u> to <u>7/14</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> <u>1961</u> , and that death occurred at <u>12 N.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>R. S. McVaugh</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R. S. McVaugh</u> | | | | 22d. ADDRESS
<u>Taneytown, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/16/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Keysville Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Keysville, Carroll, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John A. Skiles</u>
<u>C. O. Russ & Son</u> | | | | ADDRESS
<u>Taneytown, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 17 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

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2850

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07782

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
5M 7/59

MEDICAL CERTIFICATION

| | | | |
|--|---|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>301-4</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. LENGTH OF STAY IN 1b <u>3 yrs./6 mons.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | d. STREET ADDRESS <u>7005 Old Harford Rd.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Nona</u> Middle <u>Coppage F.</u> Last <u>EDWARDS</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>14</u> Year <u>1961</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/17/02</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator</u> | | 9b. AGE (In years last birthday) <u>59</u> yrs. | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>John A. Ferguson</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Lackey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) | | 17. INFORMANT <u>Springfield Hospital Records</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction.</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS assoc. with Alzheimer's Disease.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James T. Marsh</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) _____ | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>July 18, 1961</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | 22d. LOCATION (City, town, or country) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR <u>Hopping and Kirkley, Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 17 '61</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Anthony S. Frank</u> | |

DATE SIGNED

7/15/61

0370

3301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

AP

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 7792 | | | | | | | | | | | |
| 07783 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown
d. STREET ADDRESS
20 Belview Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Alice Florence Ernste | | | | | | 4. DATE OF DEATH
July 13 1961 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
September 26, 1886 | | 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
William Bryan | | | | | | 14. MOTHER'S MAIDEN NAME
Harriet Grimes | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | | | 16. SOCIAL SECURITY NO.
214-09-4793 | | 17. INFORMANT
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
590X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute and chronic nephritis.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, senile brain disease.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
INTERVAL BETWEEN ONSET AND DEATH
Months
Days and Month | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-29, 1961 to 7-13, 1961 that (I) (we) last saw the deceased alive on 7-13, 1961 , and that death occurred at 8:00 a.m. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo
22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | | | 22b. DATE SIGNED
7-13-61
22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial July 15, 1961 | | | | 23b. DATE THEREOF
July 15, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City, town or county) (State)
Hagerstown Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Rest Home Funeral Chapel Hagerstown Md.
Wm. G. Smith | | | | | | 25a. REC'D BY REGISTRAR
JUL 14 '61 | | 25b. REGISTRAR'S SIGNATURE
Charles S. Harris | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07784**

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--|--|--|-------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUMFRIES | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3 Vol-4 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
CAMP GABRIELLE | | | | d. STREET ADDRESS
1533 Byrd St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
S. LIEA Ann Feehly First Middle Last | | | | 4. DATE OF DEATH
Month 7 Day 2 Year 1961 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-12-41 | |
| 9. AGE (In years last birthday)
19 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOME | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME
LAWRENCE | | | |
| 14. MOTHER'S MAIDEN NAME
MARGARET ALLEN | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
N/A | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Family. Same Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning (accidental)
929.8 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH — | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Attempting to swim from an island in the lake and failed to make shore. | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 7-2 19 61 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Camp Gabrielle | | 20f. (City or town) (County) (State)
nr. Snydersburg Carr. Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE W. Glenn Speicher | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) W. GLENN SPEICHER acting | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
7-6-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Glenn Haven | | 22d. LOCATION (City, town, or county) (State)
Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
McClure - 130 E. Fowler | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE JUL 5 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Carlton S. Kenna | | | | | | | |

TO DISPENSE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEATH CERTIFICATE

(M)

(1)

| | | | | | | | | | |
|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|---------------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | | 5. Time of death | |
| 6. Place of death | | 7. Cause of death | | 8. Manner of death | | 9. Signature of medical examiner | | 10. Signature of attending physician | |
| 11. Signature of medical examiner | | 12. Signature of attending physician | | 13. Signature of medical examiner | | 14. Signature of attending physician | | 15. Signature of medical examiner | |
| 16. Signature of attending physician | | 17. Signature of medical examiner | | 18. Signature of attending physician | | 19. Signature of medical examiner | | 20. Signature of attending physician | |
| 21. Signature of medical examiner | | 22. Signature of attending physician | | 23. Signature of medical examiner | | 24. Signature of attending physician | | 25. Signature of medical examiner | |
| 26. Signature of attending physician | | 27. Signature of medical examiner | | 28. Signature of attending physician | | 29. Signature of medical examiner | | 30. Signature of attending physician | |
| 31. Signature of medical examiner | | 32. Signature of attending physician | | 33. Signature of medical examiner | | 34. Signature of attending physician | | 35. Signature of medical examiner | |
| 36. Signature of attending physician | | 37. Signature of medical examiner | | 38. Signature of attending physician | | 39. Signature of medical examiner | | 40. Signature of attending physician | |
| 41. Signature of medical examiner | | 42. Signature of attending physician | | 43. Signature of medical examiner | | 44. Signature of attending physician | | 45. Signature of medical examiner | |
| 46. Signature of attending physician | | 47. Signature of medical examiner | | 48. Signature of attending physician | | 49. Signature of medical examiner | | 50. Signature of attending physician | |
| 51. Signature of medical examiner | | 52. Signature of attending physician | | 53. Signature of medical examiner | | 54. Signature of attending physician | | 55. Signature of medical examiner | |
| 56. Signature of attending physician | | 57. Signature of medical examiner | | 58. Signature of attending physician | | 59. Signature of medical examiner | | 60. Signature of attending physician | |
| 61. Signature of medical examiner | | 62. Signature of attending physician | | 63. Signature of medical examiner | | 64. Signature of attending physician | | 65. Signature of medical examiner | |
| 66. Signature of attending physician | | 67. Signature of medical examiner | | 68. Signature of attending physician | | 69. Signature of medical examiner | | 70. Signature of attending physician | |
| 71. Signature of medical examiner | | 72. Signature of attending physician | | 73. Signature of medical examiner | | 74. Signature of attending physician | | 75. Signature of medical examiner | |
| 76. Signature of attending physician | | 77. Signature of medical examiner | | 78. Signature of attending physician | | 79. Signature of medical examiner | | 80. Signature of attending physician | |
| 81. Signature of medical examiner | | 82. Signature of attending physician | | 83. Signature of medical examiner | | 84. Signature of attending physician | | 85. Signature of medical examiner | |
| 86. Signature of attending physician | | 87. Signature of medical examiner | | 88. Signature of attending physician | | 89. Signature of medical examiner | | 90. Signature of attending physician | |
| 91. Signature of medical examiner | | 92. Signature of attending physician | | 93. Signature of medical examiner | | 94. Signature of attending physician | | 95. Signature of medical examiner | |
| 96. Signature of attending physician | | 97. Signature of medical examiner | | 98. Signature of attending physician | | 99. Signature of medical examiner | | 100. Signature of attending physician | |

7794

CERTIFICATE OF DEATH

Reg. Dist. No. 07785

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER | | c. LENGTH OF STAY IN 1b 50 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROUTE #2 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) GEORGE WALTER FRITZ | | 4. DATE OF DEATH Month JULY Day 15 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 16 1884 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME CHARLES W. FRITZ | | 14. MOTHER'S MAIDEN NAME CARRIE L KAUFFMAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-36-9980 | |
| 17. INFORMANT CARROLL W FRITZ Address 206 PENNA AVE WESTMINSTER, MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION & SHOCK 1 DAY
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. 10 YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 HOURS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MARCH , 19 61 , to JULY , 19 61 , that I last saw the deceased alive on JULY 15 , 19 61 , and that death occurred at 11:48 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Daniel I Welliver M.D. | | DATE SIGNED 19 RIDGE ROAD 7/15/61 | |
| PHYSICIAN'S NAME (Type) DANIEL I WELLIVER | | WESTMINSTER MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7/18/61 | 22c. NAME OF CEMETERY OR CREMATORY Frederick cemetery | 22d. LOCATION (City, town, or county) (State) Rural Westminister, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. | | 24. REC'D BY REGISTRAR JUL 18 '61 | |
| ADDRESS Westminister, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7795 CERTIFICATE OF DEATH 07786

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural--Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural--Westminster</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Bird View Road, R. D. # 6</u> | | d. STREET ADDRESS
<u>Bird View Rd. R. D. # 6</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>JOHN</u> <u>GILROY</u> | | 4. DATE OF DEATH
Month Day Year
<u>July</u> <u>28</u> , <u>19 61</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 20, 1881</u> |
| 9. AGE (In years lost birthday) yrs.
<u>80</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Stone Mason</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Owen Gilroy</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | |
| 17. INFORMANT
<u>Mrs. Gertrude Barnard, Same as 2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis, auricular fibrillation</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart les, cardiac failure</u>
DUE TO
(c) <u>arteriosclerosis generalized, atherosclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>1959 to 1961</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>28 July 1961</u> , that (I) (we) last saw the deceased alive on <u>28 July 1961</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Howard E. Hall</u> | | 22b. DATE SIGNED
<u>28 July 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Howard E. Hall, M. D.</u> | | 22d. ADDRESS
<u>Sykesville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7-30-1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Brandenburg Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Carroll Co., Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>C. M. Waltz, Winfield, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 31 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

CERTIFICATE OF DEATH

11780



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and possibly a signature area.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 7796 | | | | | | | | | | | |
| 07787 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Balto. City | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital | | | | | | d. STREET ADDRESS 1139 Homestead Street | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Louise Last Griffin | | | | | | 4. DATE OF DEATH
Month 7 Day 22 Year 1961 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 23, 1869 | | 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR
Months 7 Days 22 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Milway | | | | | | 14. MOTHER'S MAIDEN NAME Sarah Ann | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records
Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic embolism with gangrene of left leg.
454X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) _____
DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction. | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/28/56 to 7/22/61 , 19____, that (I) (we) last saw the deceased alive on 7/22 19 61 , and that death occurred at 5:29 a.m. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Julian Radzykewycz M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7/22/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. | | | | | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7-26-61 | | 23c. NAME OF CEMETERY OR CREMATORY MT. ZION | | 23d. LOCATION (City, town or county) FOUNTAIN GREEN HARBOR CO. (State) MD. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. Walter Conklin ADDRESS 5444 Belair Rd. | | | | | | 25a. REC'D BY REGISTRAR DATE JUL 26 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

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2444-1112
1112-2444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7797 CERTIFICATE OF DEATH 07788

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 19 yrs 3 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland
b. COUNTY Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS Hanover Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Jeanette | | 4. DATE OF DEATH July 24 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 1, 1900 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Grosh | | 14. MOTHER'S MAIDEN NAME Mary Jane Woodside | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
053.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Unk.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder, epileptic deterioration. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m.
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
et work <input type="checkbox"/> et work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4-24-1942 to 7-24-1961 , that (I) (we) last saw the deceased alive on 7-24-1961 , and that death occurred at 10:50 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Julian Radzykewycz M.D. | | 22b. DATE SIGNED 7-24-61 | |
| 22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL REMOVAL <input checked="" type="checkbox"/> CREMATION (Specify) | 23b. DATE THEREOF 7-26-61 | 23c. NAME OF CEMETERY OR CREMATORY Our Lady of Mercy Burial | 23d. LOCATION (City, town or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Henshaw | | 25a. REC'D BY REGISTRAR 28 '61 | |
| ADDRESS Pikes 8 m d | | 25b. REGISTRAR'S SIGNATURE Arthur S. Henshaw | |

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TO HOSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7798

CERTIFICATE OF DEATH

Reg. Dist. No. 07789

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodbine, Md | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Weitzel Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Allen Middle B. Last Hardesty | | 4. DATE OF DEATH
Month July Day 23 Year 19 61 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 25, 1865 |
| 9. AGE (In years lost birthday) 95 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
(ret'd) motorman | | 10b. KIND OF BUSINESS OR INDUSTRY
United Railway | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Addison Hardesty | | 14. MOTHER'S MAIDEN NAME
Cornelia Gray | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Riegina C. Gore, 715 Murdock Road, Baltimore 12 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Cardiac failure,
DUE TO 491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Intermittent heart D., Arteriosclerosis
DUE TO Spinalized - Cerebral hemorrhage, Chronic B.S.
(c) 13 July 61
23 July 61 | | INTERVAL BETWEEN ONSET AND DEATH
13 July 61
23 July 61 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 13 July, 1961 to 23 July, 1961 , that I last saw the deceased alive on 23 July, 1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Howard E. Hall M.D. | | ADDRESS (Street, city or town, state)
Sykesville, Md. | |
| PHYSICIAN'S NAME (Type)
Howard E. Hall | | DATE SIGNED
23 July 61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVED | | 22b. DATE THEREOF
7-26-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Towson, Inc., 1050 York Road, Towson | | 24a. REC'D BY REGISTRAR
DATE Jul 26 '61 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
William E. Hall | |

7799

CERTIFICATE OF DEATH

Reg. Dist. No. 07790

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD, R.D. #2</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Hampstead.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brick Store Rd.</u> | | | | d. STREET ADDRESS <u>1 Brick Store Rd.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>ESTEY VICTORIA HARE</u> | | | | 4. DATE OF DEATH Month Day Year
<u>July 20, 1961</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 31, 1897</u> | |
| 9. AGE (In years lost birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Mills.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hampstead, Md. R.D. #2</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. <u>Machine operator</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CINDY BAUBHITZ</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>219-10-5051</u> | | | |
| 17. INFORMANT <u>Jerry W. Hare, Hampstead R.D. #2, Maryland.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Uterine Body</u>
DUE TO <u>172X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>June 57</u> , 19 <u>57</u> , to <u>7-20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-19</u> , 19 <u>61</u> and that death occurred at <u>4:55</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>M.C. Porterfield</u> | | | | DATE SIGNED <u>7/21/61</u> | | | |
| PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>7-24-61</u> | | <u>Middletown Cemetery</u> | | <u>Freeland, Md. R.D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> | | | | 24a. REC'D BY REGISTRAR <u>Jul 26 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u> | |
| ADDRESS <u>New Freedom, Pa.</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7800 CERTIFICATE OF DEATH 07791

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Henryton | | c. LENGTH OF STAY IN 1b
1,301 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
1704 Rutland Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Henryton State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lillian Middle Harrington Last Harrington | | 4. DATE OF DEATH
Month July Day 6 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-15-1896 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 15 Hours 00 Min. 00 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY
Littleton, N. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Louis Massey | |
| 14. MOTHER'S MAIDEN NAME
Marie McLean | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Cecelia McKoy-Daughter 3203 Presstman St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tbc.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 002x
DUE TO
(c) 002x | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1960 to July 6, 1961 , that (I) (we) last saw the deceased alive on July 6, 1961 , and that death occurred at 9:00 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Edgars M. Maculans, M.D. | | 22b. DATE SIGNED
July 12 '61 | |
| 22c. PHYSICIAN'S NAME (Type)
Edgars M. Maculans, M. D. | | 22d. ADDRESS
Henryton State Hosp., Henryton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE THEREOF
7/11/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Massey Cemetery | | 23d. LOCATION (City, town, or county) (State)
Harrods, CO, N.C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
R. J. COLLIER | | 25a. REC'D BY REGISTRAR
DATE JUL 12 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. House | | | |

County of ...

State of ...

City of ...

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07792

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3 mos. 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore #2 | | 3 V 0 1 - 4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
1324 Winton St., Zone 2. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
John William Harrison, Jr. | | | | 4. DATE OF DEATH
Month Day Year
July 24, 19 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 27, 1913 | |
| 9. AGE (In years last birthday)
47 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John W. Harrison, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Hilda Arnold | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
213-16-5881 | | 17. INFORMANT
Address
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral lobar pneumonia with multiple abscesses,
490x DUE TO organism not determined.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Involutional depression (?) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. - p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE James T. Marsh
EXAMINER'S NAME (Type) James T. Marsh, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
7/24/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
7-28-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 22d. LOCATION (City, town, or country) (State)
Baltimore | |
| 23. FUNERAL DIRECTOR
Wm. Cook, Inc., 1217 St. Paul Street | | | | 24e. REC'D BY REGISTRAR
JUL 26 61
DATE | | 24b. REGISTRAR'S SIGNATURE
James T. Marsh | |

M

015

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1933

1933

M

James J. [illegible]

7-28-31

Mr. Cook, Inc., 1217 St. Paul Street

CERTIFICATE OF DEATH

Reg. Dist. No. 07793

7802

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Maryland</u> | |
| c. LENGTH OF STAY IN TB <u>14 years</u> | | d. STREET ADDRESS <u>1400 York Street</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>400 York St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CARROLL</u> Middle <u>ROSS</u> Last <u>HETRICK</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 10, 1914</u> |
| 9. AGE (In year lost birthday) <u>47</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Herbert E. HETRICK</u> | | 14. MOTHER'S MAIDEN NAME <u>Cora Leigler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>216-10-5436</u> | |
| 17. INFORMANT <u>Mrs Carroll Hetrick</u> Address <u>Manchester Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cordis Vasculare Disease</u> (?)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 1</u> , 19 <u>54</u> , to <u>July 22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>61</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. | | ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>7/23/61</u> | |
| PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | | <u>HAMPSTEAD Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>July 25/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u> | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Pipton-Eline</u> ADDRESS <u>Hampstead Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 25 '61</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1887

CERTIFICATE OF DEATH

1887

(18)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

7803

CERTIFICATE OF DEATH

Reg. Dist. No. 07794

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd. R.F.D. 2 Mt. Airy</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ludwig Martin Hilpert</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 21 19 61</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 26, 1898</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Thompson Engine Co. Owner</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Balt.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>Max Hilpert</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Barbara ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>213-09-9409</u> | | | |
| 17. INFORMANT <u>Naomi K. Hilpert</u> | | | | Address <u>R.F.D. 2 Ridge Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
DUE TO <u>Generalized Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>Several years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>61</u> , and that death occurred at <u>7:25 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. B. Culwell</u> | | | | ADDRESS (Street, city or town, state) <u>Main Street</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. B. Culwell</u> | | | | DATE SIGNED <u>7/22/61</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7/24/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Memorial Ph.</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Forrest Byers</u> | | | | ADDRESS <u>8728 Liberty Rd. Randallstown, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 26 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1977

RECEIVED

5025



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7804 CERTIFICATE OF DEATH 07795

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
1yr 4 mos 25 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Katie Louise Middle Richardson Last Hobson | | 4. DATE OF DEATH
Month July Day 6 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 7, 1874 |
| 9. AGE (In years last birthday)
86 yrs. | | 10. IF UNDER 1 YEAR
Months 86 Days 27 Hours 27 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Weaver | | 12. KIND OF BUSINESS OR INDUSTRY
- | |
| 13. BIRTHPLACE (State or foreign country)
Maryland | | 14. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. FATHER'S NAME
Joshua Richardson | | 16. MOTHER'S MAIDEN NAME
Kate Harrison | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 18. SOCIAL SECURITY NO.
- | |
| 19. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 491X
(c) 491X | | INTERVAL BETWEEN ONSET AND DEATH
days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 11, 1960 to 7-6-1961 , that (I) (we) last saw the deceased alive on 7-6-1961 , and that death occurred at 2:30 p.m. from the causes and on the date stated above. | | 22a. SIGNATURE
Agustin del Campo M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED
7-6-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-9-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd | | 23d. LOCATION (City, town, or county) (State)
Ellicott City, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. C. Richardson | | 25a. REC'D BY REGISTRAR
JUL 10 '61 | |
| ADDRESS
Ellicott City, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

1793

CERTIFICATE OF EVIDENCE

1793

M

1

Original of [illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7805

CERTIFICATE OF DEATH

07796

| | | | |
|--|-------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Road</u> | | d. STREET ADDRESS <u>1 Morgan Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Bessie</u> Middle <u>Jeanette</u> Last <u>Hoyer</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>24</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-16-1891</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John S. Sedicum</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Bowers</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT Address <u>Mrs. Ada Burrier Woodbine, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, terminal</u>
DUE TO (b) <u>pneumonia, arteriosclerosis generalized</u>
DUE TO (c) <u>recumbent</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>1460</u>
<u>70</u>
<u>24 July 61</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 <u>1961</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>24 July 1961</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Howard E. Hall</u> | | 22b. ADDRESS <u>Aylorville, Md.</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall M.D.</u> | | 22d. ADDRESS <u>Aylorville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-27-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u> | | 25a. REC'D BY REGISTRAR <u>DATE JUL 28 '61</u> | |
| ADDRESS <u>Sykesville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u> | |

(M)

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "Name", "Age", "Sex", "Cause of Death", "Place of Birth", "Date of Death", "Signature", and "Witness" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7806
CERTIFICATE OF DEATH

07798

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN lb
1 yr. 3 dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kingsville
d. STREET ADDRESS
Box 451
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Clara Elizabeth Hurline | | 4. DATE OF DEATH
Month Day Year
July 24 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 24, 1891 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Andrew J. Meisner | |
| 14. MOTHER'S MAIDEN NAME
Mary K. Schmidt | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure
DUE TO (b) 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis without qualifying phrase. | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-21-1960 to 7-24-1961 that (I) (we) last saw the deceased elive on 7-24-1961 , and that death occurred at 6:30 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Julian Radzykewycz
M.D. | | 22b. DATE SIGNED
7-24-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radzykewycz, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 26-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Johns | | 23d. LOCATION (City, town or county) (State)
Sweet's (Md) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Kurtz
ADDRESS
Jarrettsville, Md | | 25a. REC'D BY REGISTRAR
DATE
JUL 26 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

M

7808

7808

General Hospital

Department of Medicine

1st. 3 Ave.

Department of Surgery

Box 451

Department of Pathology

Department of Obstetrics and Gynecology

Department of Pediatrics

Department of Dermatology

Department of Radiology

Department of Ophthalmology

Department of Neurology

Department of Psychiatry

Department of ENT

Department of Laboratory Medicine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

7807
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
77799
CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN 1b
11m. 10days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
30 W. Potomac Street | |
| 3. NAME OF DECEASED (Type or print)
First Jane Middle Hutchinson Last Hutchinson | | 4. DATE OF DEATH
Month 7 Day 31 Year 1961 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/28/79 |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
General worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Morris | | 14. MOTHER'S MAIDEN NAME
Elizabeth McDonald | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT
Springfield Hosp. records | | Address
Sykesville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS associated with senile brain disease with psychotic reaction. | | | INTERVAL BETWEEN ONSET AND DEATH
years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/19 1960 to 7/31 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/31 1961 and that death occurred at 2:05PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ellis S. Margolin M.D. | | 22b. DATE SIGNED
7/31/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Ellis S. Margolin, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE THEREOF
8-3-61 | 23c. NAME OF CEMETERY OR CREMATORY
Cabary | 23d. LOCATION (City, town, or county) (State)
Quincy Co., New York |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arthur S. Knight | | 25. REGISTRAR'S SIGNATURE
Arthur S. Knight | |
| ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
DATE AUG 3 '61 | |

67789

CERTIFICATE OF DEATH

7207

M

[Faint, mostly illegible text from a form, likely containing personal and medical details.]

[Handwritten signature, possibly "John Doe", in the lower right section.]

[Faint, illegible text at the bottom of the page.]

1
FOR STATE
HEALTH DEPT.

delay is necessary, write RURAL and give nearest town)
M
I
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

7808
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07800

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY in lb
4 mos. 23 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 13 | | d. STREET ADDRESS
3554 Lyndale Ave. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Edward Middle Olai Last Johannesen | | | | 4. DATE OF DEATH
Month July Day 28 , Year 19 61 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 4, 1893 | 9. AGE (In years last birthday)
67 yrs. | IF UNDER 1 YEAR
Months 67 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rigger (Bethlehem Steel Company) | | 10b. KIND OF BUSINESS OR INDUSTRY
Norway | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Johannas O. Olson | | | | 14. MOTHER'S MAIDEN NAME
Marie Monsal | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No - | | 16. SOCIAL SECURITY NO.
217-01-1330 | | 17. INFORMANT
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal pulmonary thrombosis and infarction.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardio-vascular disease.
DUE TO
(c) General arteriosclerosis - severe. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
years
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
C.B.S. assoc. with cerebral arteriosclerosis. | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19 p.m. | Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 7/28/61 | | | | | | | |
| ACTUAL SIGNATURE
James T. Marsh | | EXAMINER'S NAME (Type)
James T. Marsh, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
8/1/61 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Paul's Cemetery | | 22d. LOCATION (City, town, or country) (State)
Baltimore, Md. | |
| 23. BURIAL DIRECTOR
Charles E. Schimunek | | | | 24a. REC'D BY REGISTRAR
AUG 1 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

MEDICAL CERTIFICATION

M

I

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7809

CERTIFICATE OF DEATH

07801

| | | | | | | | |
|---|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg
c. LENGTH OF STAY IN b 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Gamber Road | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg
d. STREET ADDRESS Gamber Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Bertha Emaline Keeney | | | 4. DATE OF DEATH
Month July Day 31 Year 1961 | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 27, 1883 | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR
Months 77 Days 77 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 13. FATHER'S NAME
James E. Morris | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)
No | | | 16. SOCIAL SECURITY NO.
None | | | | |
| 17. INFORMANT
Mrs. Mary Maisel, Ellicott City, Md. | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage with Left side Hemiplegia
4-22-1 DUE TO Hypertensive
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic C-V Disease
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 da.
6 yrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)
none | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | | |
| 20f. (City or town)
none | | (County) | | (State) | | | |
| 21. I certify that (I) (the hospital) attended the deceased from 3-21-41 to 7-31-61, 19, that (I) (we) last saw the deceased alive on 7-31-61, 19, and that death occurred at 6:30PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
D. D. Caples | | | 22b. DATE SIGNED
8-1-61 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
D. D. Caples, M. D. | | | 22d. ADDRESS
6 Hanover Rd., Reisterstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Aug. 6, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Finksburg Cemetery | | | |
| 23d. LOCATION (City, town or county)
Finksburg, Md. | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons, Reisterstown, Md. | | | 25a. REC'D BY REGISTRAR
DATE AUG 4 '61 | | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | | | | | |

10801

10801

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7810

07802

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | |
| c. LENGTH OF STAY IN 1b <u>81 yrs</u> | | d. STREET ADDRESS <u>210 E. Main St.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 E. Main St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY TEST KIMMEY</u> | | 4. DATE OF DEATH Month Day Year <u>JULY 24 1961</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 28, 1879</u> | |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Buckingham</u> | | 14. MOTHER'S MAIDEN NAME <u>Emily Gorsuch</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>650 Pricadilly Rd. Towson 4 Md.</u> | |
| 17. INFORMANT <u>Henry B. Kimmey</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO <u>420.0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>yes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18 1961</u> , to <u>July 24 1961</u> , that (I) (we) last saw the deceased alive on <u>July 14 1961</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James J. Marshall</u> | | 22b. ADDRESS <u>Westminster</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u> | | 22d. ADDRESS <u>Westminster</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/27/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Westminster, Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> | | 25a. REC'D BY REGISTRAR <u>Jul 28 '61</u> | |
| ADDRESS <u>Westminster, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Caroline L. Harris</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7811

07803

| | | | | | | |
|---|----------------------------------|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
4 mos. 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto. City
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 5
d. STREET ADDRESS
2020 McElderry Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
John Robert Klump | | 4. DATE OF DEATH
Month Day Year
July 25, 19 61 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 29, 1888 | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months Days
72 | IF UNDER 24 HRS.
Hours Min.
72 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Nicholas Klump | | | 14. MOTHER'S MAIDEN NAME
Ida Stout | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No - | | 16. SOCIAL SECURITY NO.
215-01-9978 | | 17. INFORMANT
Springfield Hospital Records | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute renal insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) Sepsis
DUE TO
(c) C.B.S. assoc. with cerebral arteriosclerosis. Hypertensive arteriosclerotic cardiovascular disease. Diabetes Mellitus. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days
Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)
C.B.S. assoc. with cerebral arteriosclerosis. Hypertensive arteriosclerotic cardiovascular disease. Diabetes Mellitus. | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour e.m.
p.m.
19 | Month, Day, Year
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
Springfield | (County)
MD | (State)
MD |
| 21. I certify that (I) (this hospital) attended the deceased from March 20, 1961 to July 25, 1961 , that (I) (we) last saw the deceased alive on July 25, 1961 , and that death occurred at 10:05 PM on the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
Julian Radeckowycz
M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
7/26/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radeckowycz, M.D. | | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/28/61 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 23d. LOCATION (City, town or county) (State)
Frederick Rd. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Schimunek Funeral Home Inc.
ADDRESS
2601 E. Madison Street | | | 25a. REC'D BY REGISTRAR
DATE
JUL 27 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7812 CERTIFICATE OF DEATH

07804

Carroll

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills Rural</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meadow View Nurs Home</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE - M - LEISTER.</u> | | 4. DATE OF DEATH Month Day Year <u>July 15 1961</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-24-1877</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel Spingling</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Burns</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT Address <u>Neering Brown-Manchester, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C. & disease</u>
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2.4 hr - years.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hip.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>True</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. Month, Day, Year <u>20:00 19</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Hampstead Carroll Md</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> 19 <u>61</u> , to <u>7-15</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>7-14</u> 19 <u>61</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James J. Marsh</u> | | 22b. DATE SIGNED <u>7/15/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u> | | 22d. ADDRESS <u>Winterset Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 18/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Leister's Luth.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lipton-Elmer</u> | | 24b. ADDRESS <u>Hampstead Md</u> | |
| 25a. REC'D BY REGISTRAR <u>DATE JUL 24 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u> | |

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be a medical or legal record.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07805

FOR STATE
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|-------------------------------|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
e. COUNTY Carroll
f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville
g. LENGTH OF STAY IN 1b 2 mos 8 dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12
d. STREET ADDRESS 6211 Mossway
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Elsie Lee Lewis | | 4. DATE OF DEATH
Month July Day 31 Year 1961 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE - 1896 | | 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 15 | | 11. IF UNDER 24 HRS. Hours 15 Min. 00 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Charles E. Lewis | | | | 14. MOTHER'S MAIDEN NAME Kate Pyle | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. - | | | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) 420
DUE TO (c) 420 | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction. Fracture of right hip. | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE James T. Marsh | | | | M.D. James T. Marsh, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 7-31-61 | | | | | | | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | | | Address (Street, city, town, or county) Westminster, Md. | | | | 22a. LOCATION (City, town, or country) (State) Pikesville Balto. Co. Md | | | | 22b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 8-3-1961 | | | | 22c. NAME OF CEMETERY OR CREMATORY David Ridge | | | | 22d. REGISTRAR'S SIGNATURE Arthur L. Hume | | | | | | | |
| 23. FUNERAL DIRECTOR Glenn F. Seitz | | | | ADDRESS 5209 York rd Baltimore 12 Md | | | | 24a. REC'D BY REGISTRAR AUG 2 '61 | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | | | | | |

MEDICAL CERTIFICATION

1500

1500

M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7814

CERTIFICATE OF DEATH

07806

| | | | | | |
|--|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | c. LENGTH OF STAY IN 1b 3Mos - 24das | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | d. STREET ADDRESS 3004 Woodside Ave. | | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Albert Last Magee | | | 4. DATE OF DEATH
Month July Day 4 Year 19 61 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/21/92 | 9. AGE (In years last birthday) 68 yrs. | IF UNDER 1 YEAR
Months 11 Days 13 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania |
| 13. FATHER'S NAME David Francis Magee | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME Lewrainer G. Twaddell | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 187-05-3967 | | | 17. INFORMANT Springfield State Hospital Records Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bacteremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Suppurative Nephritis
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 10 1961 , to July 4 1961 , that (I) (we) last saw the deceased alive on July 4 1961 , and that death occurred at 1233 P.M., from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Agustin del Campo | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) | | | 22d. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 7-8-61 | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | 23d. LOCATION (City, town, or county) BALTIMORE Md (State) | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Leman J. Kuck ADDRESS 5305 Harford Rd | | | 25a. REC'D BY REGISTRAR
DATE JUL 6 '61 | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M



7815

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07807

| | | | | | | | | |
|---|--|-------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY City ✓ | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | c. LENGTH OF STAY IN 1b
1yr. 1mo. 24days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
Unknown - Came from jail. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Mildred McClanahan | | | | 4. DATE OF DEATH Month Day Year
July 10, 1961 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 11, 1920 | | |
| 9. AGE (In years last birthday)
40 yrs. | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Governess | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Illinois | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | | |
| 13. FATHER'S NAME
John McLanahan | | | | 14. MOTHER'S MAIDEN NAME
Vera Fleming | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Address
Springfield Hospital Records | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
DUE TO (c) Schizophrenic reaction, chronic undifferentiated type.
Pulmonary tuberculosis.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Hours
Years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 16, 1961 to July 10, 1961 , that (I) (we) last saw the deceased alive on July 10, 1961 and that death occurred at 4:30PM from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo | | | | 22b. DATE
7/10/61 | | 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | |
| 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-14-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Freedom | | 23d. LOCATION (City, town, or county) (State)
Sykesville, Carroll Co. Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arthur H. Hight | | | | 25a. REC'D BY REGISTRAR
DATE JUL 17 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hight | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1904

OFFICE OF THE DEATH

M

1904

CERTIFICATE OF DEATH

Reg. Dist. No. 07808

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Westminster, Md. | | c. LENGTH OF STAY IN 1b
2 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
--- | | d. STREET ADDRESS
Baltimore Blvd. | |
| 3. NAME OF DECEASED
(Type or print) Effie Susan Dean McComas | | 4. DATE OF DEATH
Month July Day 15 Year 1961 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 29, 1884 |
| 9. AGE (In years birthday) yrs.
77 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Richard Owings | | 14. MOTHER'S MAIDEN NAME
Francois E. Shipley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or type of service] | | 16. SOCIAL SECURITY NO.
220-05-9581D | |
| INFORMANT
Son Lewis W. McComas Sr. | | Address
Rd #4 Westminster, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis - chronic
260X DUE TO De-compensating
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO Diabetes - mellitus
(c) Diabetes - mellitus | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs
2 yrs
5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 7-14-61 to 7-15-61 , that I last saw the deceased alive on 7-14-61 , and that death occurred at 06 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James G. Saffell | | ADDRESS (Street, city or town, state) 64 Main St. Reisterstown, Md. | |
| PHYSICIAN'S NAME (Type) Dr. James G. Saffell Sr. | | DATE SIGNED 7-16-61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
7/18/61 | 22c. NAME OF CEMETERY OR CREMATORY
Deer Park Methodest Cem. | 22d. LOCATION (City, town, or county) (State)
Reisterstown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James G. Saffell | | 24. REC'D BY REGISTRAR
DATE JUL 18 '61 | |
| 25. ADDRESS
254 E. Main St. Westminster, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneale | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2025

UNITED STATES OF AMERICA

1918

Serial

Page



Control

UNITED STATES OF AMERICA

Serial

15

1918

UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA

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[Faint, illegible text]

[Faint, illegible text]

James H. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07809

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u> | | c. LENGTH OF STAY IN 1b <u>35 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>378 N. MAIN ST</u> | | d. STREET ADDRESS <u>378 N. MAIN</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>NORMAN Edgar Murray</u> | | 4. DATE OF DEATH Month Day Year <u>July 29 1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 21 1893</u> |
| 9. AGE (In years lost birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Const.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Elsworth Murray</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Blizzard</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>216-01-5040</u> | |
| 17. INFORMANT Address <u>Mrs Fannie Murray. HAMPSTEAD MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Primary Carcinoma of Stomach</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/22/61</u> to <u>7/29</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/29</u> 19 <u>61</u> , and that death occurred at <u>6:27</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Joseph E. Bush</u> M.D. | | 22b. DATE SIGNED <u>7/29/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush, MD</u> | | 22d. ADDRESS <u>Hampstead Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug 1-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u> | | 23d. LOCATION (City, town, or county) (State) <u>Chesapeake Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 2 '61</u> | |
| ADDRESS <u>Hampstead Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u> | |

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a certificate of death, containing fields for name, date, and place of death.]

(1)

(1)

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7818

CERTIFICATE OF DEATH

07810

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Taneytown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Taneytown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>R.F.D. #1</u> | | d. STREET ADDRESS
<u>R.F.D. #1</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Emma</u> Middle <u>Savilla</u> Last <u>Ohler</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>23</u> Year <u>1961</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 11, 1889</u> |
| 9. AGE (In years lost birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John H. Cluts</u> | | 14. MOTHER'S MAIDEN NAME
<u>Hettie Ritter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mr. Raymond Ohler, R #1, Taneytown, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u>
430.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO
(c) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DIS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY INSUFFICIENCY</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 HR.</u>
<u>4 YRS</u>
<u>4 YRS.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1957</u> to <u>7-22-61</u> , that (I) (we) last saw the deceased alive on <u>7-22-61</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James H. Allison</u> | | 22b. DATE SIGNED
<u>7-25-61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES H. ALLISON M.D.</u> | | 22d. ADDRESS
<u>508 S. WASHINGTON ST. GETTYSBURG, PA.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>July 27, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lutheran Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Taneytown, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>C.O. Fuss & Son</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 27 '61</u> | |
| ADDRESS
<u>Taneytown, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanes</u> | |

CERTIFICATE OF DEATH

1918

(N)

(1)

John F. Ryan, aged 40 years,
born at [illegible],
and died at [illegible] on [illegible] day of [illegible] 1918.
Cause of death: [illegible]
[illegible] [illegible] [illegible]

John F. Ryan

John F. Ryan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07811

7819

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | c. LENGTH OF STAY IN 1b
11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 24 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
323 S. Bouldin Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Joseph Last Ovelgone | | | | 4. DATE OF DEATH
Month July Day 10 Year 1961 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 2, 1906 | | 9. AGE (In years lost birthday) 54 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trucking - Penna. Railroad | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Henry Ovelgone | | | | 14. MOTHER'S MAIDEN NAME
Mary Siber | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Address
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
C.B.S. assoc. with diseases of uncertain or unknown cause (Huntington's Chorea) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 29, 1961 to July 10, 1961 , that (I) (we) last saw the deceased alive on July 10, 1961 , and that death occurred at 2:20 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE
7/10/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
7-13-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City, town, or county) (State)
Colgate, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home, Dundalk, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JUL 12 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11570

RECEIVED

11570

11570



TO HOLD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7820

07812

| | | | | | |
|--|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
9yrs.5mos.13days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
708 Dryden Drive | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Raymond Middle Archie Last Phebus | | 4. DATE OF DEATH
Month July Day 13 Year 1961 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 3, 1895 | | |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Banking | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Eugene Phebus | | 14. MOTHER'S MAIDEN NAME
Florence Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO.
216-03-8008 | | | |
| 17. INFORMANT
Springfield Hospital Records | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic heart disease
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - | | | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Presenile psychosis. Pick's Disease of the brain. | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 1966 to July 13, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 2:45PM from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Agustin del Campo | | M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
7/13/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/17/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | |
| 23d. LOCATION (City, town, or county)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ellsworth Umacost | | 25a. REC'D BY REGISTRAR
JUL 17 1961 | | 25b. REGISTRAR'S SIGNATURE
Charles L. Kline | |

1912

REPUBLIC OF CHINA

1912

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7821
CERTIFICATE OF DEATH
07813

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Bunnell</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Bunnell</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> | | c. LENGTH OF STAY IN 1b <u>20-yr</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LAURA - MAY - PHILLIPS</u> | | 4. DATE OF DEATH <u>July 25</u> 19 <u>61</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 12 - 1885</u> |
| 9. AGE (If years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nick</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Edw Stiller</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Youngling</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>189-05-4665</u> | |
| 17. INFORMANT <u>Chas Phillips</u> | | Address <u>Hampstead Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Carcinoma of Lung</u>
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>
<u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>60</u> , to <u>July 25</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>July 24</u> 19 <u>61</u> , and that death occurred <u>8:15 AM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>M.C. Porterfield</u> | | 22b. DATE SIGNED <u>7/25/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u> | | 22d. ADDRESS <u>Hampstead, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 27/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Stygiesburg</u> | | 23d. LOCATION (City, town, or county) (State) <u>Bunnell Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>ELINE - Hampstead Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

61819

CERTIFICATE OF DEATH

1921

(M)

(I)

A. B. C.

D. E. F.

G. H. I.

J. K. L.

M. N. O.

P. Q. R.

S. T. U.

V. W. X.

Y. Z. A.

B. C. D.

E. F. G.

H. I. J.

K. L. M.

N. O. P.

Q. R. S.

T. U. V.

W. X. Y.

Z. A. B.

C. D. E.

F. G. H.

I. J. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7822

CERTIFICATE OF DEATH

07814

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> ✓ | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u> | | d. STREET ADDRESS <u>50 John St.</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last <u>Lillie Belle PHILLIPS</u> | | 4. DATE OF DEATH
Month Day Year <u>7 - 22 1961</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/1/83</u> |
| 9. AGE (in years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Carroll, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Edmondson</u> | | 14. MOTHER'S MAIDEN NAME <u>Parrish</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Springfield Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Active pulmo-hary TB - advanced.</u> | | | |
| DUE TO (b) <u>002X</u> | | | |
| DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/28/60</u> 19 to <u>7/22/61</u> 19 that (I) (we) last saw the deceased alive on <u>7/22/61</u> 19 and that death occurred at <u>2 AM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Julian Radzykewycz</u> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22b. DATE SIGNED <u>7/22/61</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Julian Radzykewycz, M.D.</u> | |
| 22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/24/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Gambier, Carroll Co. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>JUL 25 '61</u> | |

1981

UNITED STATES OF AMERICA

1981



Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Some visible words include "UNITED STATES OF AMERICA", "1981", and "M".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

515

VR A15 (4)
15M 9/60

1
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7823
CERTIFICATE OF DEATH
07815

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY in lb
46yrs11mos6dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 24
d. STREET ADDRESS
4401 E. Lombard Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Mary
First Middle Last
Poloha | | 4. DATE OF DEATH
July 25 1961
Month Day Year | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1894 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Austria | | 12. CITIZEN OF WHAT COUNTRY?
Austria | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Schizophrenic reaction, hebephrenic type. Bronchiectasis. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-19-1961 to 7-25-1961 , that (I) (we) last saw the deceased alive on 7-25-1961 , and that death occurred at 7:00 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Julian Radzykewycz
M.D. | | 22b. DATE SIGNED
7-25-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radzykewycz, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-26-61 | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters | 23d. LOCATION (City, town or county) (State)
Baltimore Md |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Thomas J. Kennedy | | 25. REC'D BY REGISTRAR
28 '61 | |
| ADDRESS
Hollins & Holmes | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Evans | |

1272

1272



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7824

CERTIFICATE OF DEATH

07816

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Sykesville | | c. LENGTH OF STAY IN 1b
4 years 4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
306 E. North Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Florence Last PURNELL | | 4. DATE OF DEATH
Month July Day 23 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-26-72 |
| 9. AGE (in years lost birthday)
88 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher - Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edward D. Halbert | | 14. MOTHER'S MAIDEN NAME
Georgia Hall | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA CARDIAC FAILURE
DUE TO (b) CHRONIC BRAIN SYNDROME SENILITY
c PSYCHOSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 7-19 19 61 to 7-23 19 61 , that (X) (we) last saw the deceased alive on 7-23 19 61 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Gertrude M. Gross, M.D. | | 22b. DATE SIGNED
7-24-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Gertrude M. Gross, M. D. | | 22d. ADDRESS
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 23b. DATE THEREOF
7-28-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION (City, town, or county) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
WILLIAM COOK, Inc. 1217 St. Paul St. BALTIMORE | | 25a. REC'D BY REGISTRAR
JUL 28 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

0318

CENTRE OF DEATH

7324

M

I

2



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7825

07817

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
e. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | c. LENGTH OF STAY IN 1b
3 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
1818 E. Baltimore Street | | | |
| 3. NAME OF DECEASED
(Type or print)
First Elsie Middle Rawlins Last Rawlins | | | | 4. DATE OF DEATH
Month July Day 31 Year 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
42 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Softening of the brain
DUE TO
(b) Carotid artery thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Pulmonary edema
Myocardial failure | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE James T. Marsh | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED 7-31-61 | | | |
| | | | | Address (Street, city, town, or county) Westminster, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | |
| Burial | | 8-3-61 | | Flag Pond | | Flag Pond, Tenn. | |
| 23. FUNERAL DIRECTOR
Arthur A. Haight | | ADDRESS
Sykesville, Md. | | 24a. REC'D BY REGISTRAR
DATE AUG 3 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Haight | |

CERTIFICATE OF DEATH

Reg. Dist. No. **07818**

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminister | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frizzelburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Carroll Co. Home for Aged | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First James Middle Roy Last Sherfey | | 4. DATE OF DEATH
Month July Day 23 Year 19 61 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 12, 1890 |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel D. Sherfey | | 14. MOTHER'S MAIDEN NAME
Amanda Kump | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT
Paul Sherfey | | Address
Rocky Ridge, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) As Thrombosis
443X DUE TO Hypertension -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic
DUE TO Cardiovascular Disease
(c) Chronic
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | INTERVAL BETWEEN ONSET AND DEATH
2 mo |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. X 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1-5-59 to 7-22 1961 , that I last saw the deceased alive on 7-22 1961 , and that death occurred at A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE M. C. Stone M.D. | | ADDRESS (Street, city or town, state) Westminister DATE SIGNED 7-23-61 | |
| PHYSICIAN'S NAME (Type) M. C. Stone | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 22b. DATE THEREOF
7-25-61 | 22c. NAME OF CEMETERY OR CREMATORY
Creagerstown Cemetery | 22d. LOCATION (City, town, or county) (State)
Creagerstown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond S. Creager | | ADDRESS
Thurmont, Md. | 24a. REC'D BY REGISTRAR
DATE JUL 25 '61 |
| | | 24b. REGISTRAR'S SIGNATURE
Charles E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1938
March

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7827

07819

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> | | c. LENGTH OF STAY IN 1b <u>10 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>11</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA GERTRUDE SMITH</u> | | 4. DATE OF DEATH Month Day Year <u>July 24 1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 1, 1869</u> |
| 9. AGE (In years lost birthday) <u>91</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Fredenck Co. Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel D. Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Domeside</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT Address <u>Mr Nicholas Metcalfe, New Windsor, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>6 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral softening 3 yrs</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 30 1961</u> to <u>July 24 1961</u> that (I) (we) last saw the deceased alive on <u>June 24 1961</u> and that death occurred at <u>AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ernest Wilkens</u> M.D. | | 22b. DATE SIGNED <u>7/25/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ERNEST WILKENS</u> | | 22d. ADDRESS <u>15 Kemper Westmunde</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/26/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope, Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Woodbury Fred Co. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 28 61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u> | | | |

1118

STATE OF TEXAS

1118



10 1st day of June 1881

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7828

07820

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Keymar</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Keymar</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u>Norris</u> Last <u>Starr</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>4</u> Year <u>1961</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 2, 1875</u> |
| 9. AGE (In years last birthday)
<u>86</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Contractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Building</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Carroll Co., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James T. Starr</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary R. Crouse</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>215-18-2924</u> | |
| 17. INFORMANT
<u>Mr. Neurow Nusbaum, Keymar, Md. R.D.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Senility</u>
794X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8 1961</u> to <u>July 4 1961</u> that (I) (we) last saw the deceased alive on <u>July 3 1961</u> and that death occurred at <u>1 AM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>J. R. Legg</u>
<u>T. H. LEGG MD</u> | | 22b. DATE SIGNED
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
<u>Union Bridge Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>July 6, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Pipe Creek Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Rural New Windsor, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>C.O. Fuss & Son</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 7 '61</u> | |
| ADDRESS
<u>Taneytown, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Frank</u> | |

1228

CERTIFICATE OF DEATH

(M)

1. Name of deceased

John Doe

2. Date of death

12/12/1912

3. Place of death

Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7829

07821

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Park ave Extended</u> | | d. STREET ADDRESS <u>1 Park ave. Extended</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Irvin Gilmore Stevig</u> | | 4. DATE OF DEATH Month Day Year <u>July 28 1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 15 1889</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Henry Stevig</u> | | 14. MOTHER'S MAIDEN NAME <u>Orrie M. Keller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT Address <u>Mrs Ada Stevig, Manchester Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>
DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u>
DUE TO (c) <u>Bronchial Asthma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 19 1961</u> to <u>July 28 1961</u> , that (I) (we) lost the deceased alive on <u>July 26 1961</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Joseph E. Bush</u> M.D. | | 22b. DATE SIGNED <u>7/28/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | | 22d. ADDRESS <u>HAMPSTEAD, Maryland</u> | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/31/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Manchester Carroll</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher Lawner Jr</u> | | 25a. REC'D BY REGISTRAR <u>DATE JUL 31 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | |

(M)

(I)

[Faint, illegible handwriting, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwriting, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7830

CERTIFICATE OF DEATH

Item 2 Film G291 7/29/61

07822

| | | | | | | |
|--|----------------------------------|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
(Rural) Sykesville
c. LENGTH OF STAY IN 1b
40y 9m. 14d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
d. STREET ADDRESS
unknown
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
John
Middle
Thomas
Last
Swan | | 4. DATE OF DEATH
Month
7
Day
9
Year
1961 | | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-9-1885 | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months
Days
Hours
Min. | IF UNDER 24 HRS.
Months
Days
Hours
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
--None | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
William D. Swan | | | 14. MOTHER'S MAIDEN NAME
Anne Lee Reeder | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Hospital Records
Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bi-lateral Pneumonia
490X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9/1 1961 to 7/9 1961 , that (I) (we) last saw the deceased alive on 7/9 1961 , and that death occurred at 8:30 am from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
Yasuo Takahashi
M.D. | | 22b. DATE
7-9-61 | | 22c. PHYSICIAN'S NAME (Type)
Yasuo Takahashi M.D. | | 22d. ADDRESS
Springfield State Hospital |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-14-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Freedom | | 23d. LOCATION (City, town, or county) (State)
Sykesville, Carroll Co. Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arthur H. Haight
ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
DATE
JUL 17 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Frank | | |

033030

CERTIFICATE OF DEATH

2830

(M)



7831

CERTIFICATE OF DEATH

07823

Item 12 Film G-91 7/24/61 iwk

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg
c. LENGTH OF STAY IN b 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Westminster Road | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg
d. STREET ADDRESS Old Westminster Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Martin Last Taylor | | | | 4. DATE OF DEATH
Month July Day 16 Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 21, 1885 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR
Months 7 Days 16 | | IF UNDER 24 HRS.
Hours 16 Min. 30 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Turnkey at Jail | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) England | |
| 12. CITIZEN OF WHAT COUNTRY? England | | | | | | | |
| 13. FATHER'S NAME Frederick Taylor | | | | 14. MOTHER'S MAIDEN NAME Orpah Martin | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. 217-18-1982A | | 17. INFORMANT Mrs. Mildred DeMoss, Finksburg, Md.
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Cancer of lungs
163X DUE TO Cachexia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Coronary Insufficiency | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 3 month | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-15-61 to 7-16-61 , that (I) 7-15-61 saw the deceased alive on 7-15-61 , and that death occurred at 7 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE James G. Saffell M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE 7-17-61 | |
| 22c. PHYSICIAN'S NAME (Type) James G. Saffell MD | | | | 22d. ADDRESS Reisterstown, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 18, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery | | 23d. LOCATION (City, town or county) (State) Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR JUL 18 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7832

07824

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shicksville</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Shicksville</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>GUY</u> Middle <u>-</u> Last <u>THOMAS</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>28</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>May 13, 1884</u> | AGE (In years last birthday) <u>77</u> yrs. |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | IF UNDER 1 YEAR
Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u> | IF UNDER 24 HRS.
Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Springfield Hospital</u> | 11. BIRTHPLACE (State or foreign country) <u>md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>James Thomas</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Alberta Harding</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Miss Ethel Thomas - Shicksville, md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic heart</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>deux, emphysema, arteriosclerosis</u>
(c) <u>gen - senility</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1954</u>
<u>↓</u>
<u>1961</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> 19 to <u>1961</u> 19, that (I) (we) last saw the deceased alive on <u>28 July</u> 19 <u>61</u> , and that death occurred at <u>200 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Howard E. Hall</u> M.D. | | 22b. DATE SIGNED <u>28 July 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u> | | 22d. ADDRESS <u>Shicksville, md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-31-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u> | | 23d. LOCATION (City, town, or county) (State) <u>Shicksville, md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Shicksville, md.</u> | | 25a. RECEIVED BY REGISTRAR DATE <u>Aug 1 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u> | | | |

CERTIFICATE OF DEATH

1922

M

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07825

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
14yrs. 7mos. 12dys. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Chevy Chase, Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
4504 Ridge Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
George Hollingsworth Wolford | | | | 4. DATE OF DEATH
Month Day Year
July 10 1961 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 3, 1899 | |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bicycle repairman | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Harry C. Wolford | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth M. Allison | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis
(a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Paranoid condition, plus Friedreich's ataxia. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<i>James T. Marsh</i>
EXAMINER'S NAME (Type) James T. Marsh, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED
7-10-61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/12/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 22d. LOCATION (City, town, or country) (State)
Rockville, Maryland | |
| 23. FUNERAL DIRECTOR
ADDRESS
Robert A. Pumphrey Bethesda, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE JUL 13 '61
24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Hanna</i> | | | |

MEDICAL EXAMINATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7834

07826

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 3 mos. 16dys. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 | | d. STREET ADDRESS 3512 Hillsmere Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Abbiegale Last Yealdhall | | 4. DATE OF DEATH
Month July Day 10 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 18, 1883 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper/Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Nichols | | 14. MOTHER'S MAIDEN NAME Susan Green | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 420.0
(c) Diabetes Mellitus. Bronchopneumonia. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. with cerebral arteriosclerosis with psychotic reaction. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-24-1961 to 7-10-1961 that (I) (we) last saw the deceased alive on 7-10-1961 , and that death occurred at 6:58 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Agustin del Campo M.D. | | 22b. DATE SIGNED 7-10-61 | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Balto. National Cem. | | 23b. DATE THEREOF 7-14-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem. | | 23d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Carroll | | 25a. REC'D BY REGISTRAR JUL 21 1961 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | DATE | |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7835

CERTIFICATE OF DEATH

Reg. Dist. No. 07827

| | | | |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2271 Colonial Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>BENJAMIN HAYES YOUNG</u> | | 4. DATE OF DEATH Month Day Year
<u>JULY 14, 1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 5 1878</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired employe of lumber Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joshua D. Young</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Magdalene Long</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-01-1701</u> | |
| 17. INFORMANT <u>Walter R. Young, Same address</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>527.1 CONGESTIVE HEART FAILURE</u>
DUE TO (b) <u>PULMONARY EMPHYSEMA</u>
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 DAYS</u>
<u>10 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>SEPT., 1953</u> , to <u>JULY 14, 1961</u> , that I lost saw the deceased alive on <u>JULY 14, 1961</u> , and that death occurred at <u>11:00 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William J. Stewart, M.D.</u> | | ADDRESS (Street, city or town, state) <u>19 RIDGE RD. WESTMINSTER, MD</u> | |
| DATE SIGNED <u>7/14/61</u> | | | |
| PHYSICIAN'S NAME (Type) <u>WESTMINSTER, MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/17/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyers, Jr.</u> | | ADDRESS <u>Westminster, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JUL 18 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clifton L. Evans</u> | |

TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7836
CERTIFICATE OF DEATH

07828

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
5mos.13days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Balto. City
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 6
d. STREET ADDRESS
3621 White Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Alvin
First Middle Last
Zschunke | | 4. DATE OF DEATH
Month Day Year
July 14, 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 6, 1879 |
| 9. AGE (In years last birthday)
82 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Gothold Zschunke | | 14. MOTHER'S MAIDEN NAME
Ernestine Theme | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO
(b) Infected bed sores
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) C.B.S. assoc. with senile brain disease with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH
Days
Weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from February 1, 1961 to July 14, 1961 that (I) (we) last saw the deceased alive on July 14, 1961 , and that death occurred at 9:45 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Julian Radcykowycz
M.D. | | 22b. DATE SIGNED
7/14/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radcykowycz, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
7/17/61 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | 23d. LOCATION (City, town or county) (State)
BALTIMORE MD |
| 24. FUNERAL DIRECTOR'S SIGNATURE
L. J. Ruck | | 25a. REC'D BY REGISTRAR
DATE JUL 18 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Charles L. Thomas | | | |

